STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155630 06/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 904 EAST 11TH STREET FLATROCK RIVER LODGE RUSHVILLE, IN46173 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0000 Preparation and execution of this This visit was for a Recertification and F0000 plan of correction does not State Licensure Survey. constitute admission or agreement by this facility of the Survey dates: June 20, 21, 22, 23, and 24, truth of the facts alleged or conclusions set forth in the 2011 Statement of Deficiencies. The Plan of Correction is prepared Facility number: 001126 and executed soley because the Provider number: 155630 provisions of federal and state AIM number: 200011300 law require it. The facility maintains that the alleged deficiencies do not individually or Survey team: collectively jeopardize the health Barbara Gray RN TC and safety of residents nor are they of such character as to limit Sharon Lasher RN the facility's capacity or render Leslie Parrett RN adequate care. This Plan of Angel Tomlinson RN correction shall constitute this (June 20, 21, 22, and 23, 2011) facility's credible allegation of compliance. Census bed type: SNF: 9 NF: 38 Residential: 12 NCC: 7 Total: 66 Census payor type: Medicare: 9 Medicaid: 38 Other: 19 Total: 66 Sample: 14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

55UK11

Facility ID:

001126

TITLE

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	155630		LDING	00	06/24/2011
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				ST 11TH STREET	
FLATRO	CK RIVER LODGE			RUSHV	ILLE, IN46173	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
	These deficiencie	es reflect state findings				2.112
	cited in accordan	ce with 410 IAC 16.2.				
Quality review completed 6/29/11						
	Cathy Emswiller	RN				
F0157	A facility must imm	nediately inform the				
SS=D	resident; consult w	vith the resident's physician;				
		y the resident's legal an interested family member				
	•	ccident involving the				
		ults in injury and has the				
		ing physician intervention; a in the resident's physical,				
		social status (i.e., a				
	deterioration in hea					
		s in either life threatening all complications); a need to				
		nificantly (i.e., a need to				
		sting form of treatment due				
		uences, or to commence a nent); or a decision to				
		ge the resident from the				
	facility as specified	d in §483.12(a).				
	The facility must a	lso promptly notify the				
		own, the resident's legal				
	•	nterested family member ange in room or roommate				
		ecified in §483.15(e)(2); or				
	a change in reside	nt rights under Federal or				
	•	ations as specified in				
	paragraph (b)(1) o	DI UNS SECUON.				
		ecord and periodically				
		s and phone number of the presentative or interested				
	family member.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155630 06/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 904 EAST 11TH STREET FLATROCK RIVER LODGE RUSHVILLE, IN46173 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on interview and record review the F0157 The facility does notify the 07/24/2011 physician and family of residents facility failed to notify the physician and that acquire pressure ulcers at family of two residents that acquired the facility. Treadment orders for pressures ulcer at the facility for 2 of 6 Resident #43 open areas were clarified on 6-20-11. The resident residents sampled for pressure ulcers in a and the resident's family received total sample of 14 (Resident #43 and notification of the change in MD Resident #23). orders on 6-20-11. The facility DON or designee will review Findings include: medical records of all current residents for changes in status or condition as defined in 483.10(b) 1.) Review of the record of Resident #43 (11). The DON or designee shall on 6-20-11 at 12:45 p.m., indicated the ensure the notification of parties resident's diagnoses included, but were is completed and documented as required.CNA staff shall not limited to, Cerebral Vascular Accident document and immediately report (CVA) (stroke), breast cancer with met's any skin irregularities to the nurse (spread) to the lymph nodes and and document the observations spine/bone, diabetes mellitus and left on the CNA sheets.24 Hour Report and CNA assignment hemiplegia. sheets will be reviewed daily by the ID team to ensure resident The pressure sore, stasis ulcer and other skin conditions changes are skin sheet dated, 6-6-11, for Resident #43 identified, and communicted to parties as required...The MD and indicated the resident acquired a stage II family notification protocols have pressure ulcer at the facility on her left been reviewed and are consistent buttock, measuring 1 cm by 0.6 cm. The with current accepted standards area was purple and red. The treatment of practice. Licensed nursing staf and the ID team shall be was Calmoseptine every shift and as inserviced on notification needed. There was documentation of the requirements (F-157) The DON pressure ulcer on the resident's coccyx or designee shall monitor for until 6-13-11, pressure sore stasis ulcer compliance by conducting audits weekly for 8 weeks then monthly and other skin sheet that indicated the for 4 months to ensure continued resident had acquired the area on 6-6-11. compliance. Negative findings will be reported to the QA The physician order for Resident #43 committee. Monitoring by Administrator and dated, 6-7-11, indicated the resident was

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155630		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 06/24/2	LETED	
	PROVIDER OR SUPPLIER			904 EAS	ADDRESS, CITY, STATE, ZIP CODE ST 11TH STREET ILLE, IN46173		
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	needed to coccyy order for the trea	ptine every shift and as x. There was no physician the the pressure buttocks, until 6-20-11.			DON Completion by 7-24-1	1	
	#43 dated, 6-8-1 had a stage II pre buttock, measuri	gress notes for Resident 1, indicated the resident essure sore on the left ng 1 cm by 0.6 cm. There tation of the pressure dent's coccyx.					
	skin sheet dated, resident acquired on the coccyx in measuring 1.5 cr was Calmoseptin needed. The resident	e, stasis ulcer and other 6-13-11, indicated the d a stage II pressure ulcer the facility on 6-6-11, m by 1 cm. The treatment ne every shift and as dent's pressure ulcer on neasured 2.4 cm by 0.5					
	p.m. indicated shareatment order for pressure ulcer or for one dated for a telephone orde p.m. for Residen resident was order coccyx open area needed and order	N #1 on 6-20-11 at 2:40 he was unable to find an for Resident #43's he the left buttock except he 6-20-11. RN #1 provided or dated, 6-20-11 at 1:50 ht #43 that indicated the hered Calmoseptine to he every shift and as hered Calmoseptine to left here difference if the left if the left and as hered defended until					

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NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	p	STREET A	DDRESS, CITY, STATE, ZIP CODE		
FLATRO	CK RIVER LODGE				ILLE, IN46173		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	6-20-11 at 2:45 p had been treating pressure ulcers w wound nurse ind physician had we area's, but he did indicated she did #43's treatment, wound nurse ind	ne wound nurse on o.m., indicated the facility g both of Resident #43's with Calmoseptine. The icated she thought the rote an order for both a not. The wound nurse a not usually do Resident that LPN #5 did. The icated she was not sure and felt that it was an					
	what happened and felt that it was an miscommunication. Interview with the Director Of Nursing						
	(DON) on 6-21- there was no doc physician or fam Resident #43's p The DON indica documentation of notification of R the left buttock g The DON indica responsible to no pressure ulcers. wound nurse was another nurse was whoever receive	11 at 3:00 p.m. indicated sumentation of the ily notification of ressure ulcers on 6-6-11.					
	on 6-22-11 at 12	ne record of Resident #23 :05 p.m., indicated the ses included, but were					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		155630	B. WING			06/24/2	011
NAME OF F	PROVIDER OR SUPPLIER		·	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					ST 11TH STREET		
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	BEIGERGI		DATE
	· ·	ebility, dementia and					
	anemia.						
	The MDC cases						
		ment for Resident #23					
		dicated the following:					
		al dependence of one					
		total dependence of one					
		room- did not occur,					
	^ -	e- total dependence of one					
	*	ontinence- frequently					
		powel continence-					
	frequently incom	tinent.					
	The proggues cor	a wound stock ulaar					
	_	e, wound, stasis ulcer					
		esident #23 dated,					
	· ·	ed the resident acquired					
		are ulcer on the left					
		cility measuring 1.3 cm					
	by 0.6 cm, the ar						
	-	treatment was Baza clear					
		and as needed. There					
		tation the physician was					
		tment ordered by the					
	physician.						
	The physician of	don dotad 6 16 11					
	1 1	der dated 6-16-11 nt #23 was ordered sween					
		tock pressure area every					
	shift.						
	Interview with th	ne DON on 6-23-11 at					
		queried about Resident					
		aza cream to the left					
	bullock and no d	ocumentation of the					

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AND TEAN	or conduction	155630	- 1	LDING	00	06/24/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	ST 11TH STREET		
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TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DLI ICILICI I		DATE
	1	ian or family being					
	1	ressure ulcer on 6-13-11,					
		ed the facility got a					
	1	For treatment of the					
	1 ^	re ulcer on 6-16-11. This					
		ility was applying Baza					
	1	prior to obtaining a					
		For the treatment of					
	Resident #23'S p	ressure ulcer.					
	The facility "Skin Treatment Management						
	Protocol" provide	ed by the Administrator					
	on 6-22-11 at 2:3	30 p.m., included, but					
	were not limited	to, the following: An					
	stage II pressure	ulcer is partial thickness					
	loss of dermis pr	esenting as a shallow					
	open ulcer with a	red pink wound bed,					
	without slough.	The treatment protocol is					
	notify the physic	ian/obtain					
	orders/diagnosis.	Notify the Power Of					
	Attorney (POA)/	Legal representative.					
	Notify the wound	d nurse and person at risk					
	committee and 2	4 hour report entry.					
	Re-evaluate/impl	lement prevention					
	interventions.						
	The "Change in I	Resident's					
	1	: Resident, Physician and					
	Family/Legal Re	_					
	Notification/Con	•					
		Administrator on 6-22-11					
	1 1	icated the purpose was					
	1 * ′	promptly notify the					
		dent's attending physician					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155630		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE COMPI 06/24/2	LETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 904 EAST 11TH STREET RUSHVILLE, IN46173					
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	interested family	legal representative or member of changes in dition and/or status.						
F0279 SS=D	The facility must d care plan for each measurable object a resident's medic psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psych required under §44 would otherwise but are not provide exercise of rights or right to refuse treat Based on intervise	velop, review and revise the nensive plan of care. evelop a comprehensive resident that includes rives and timetables to meet al, nursing, and mental and les that are identified in the	F0279	The facility does develo of care to prevent urinal infection for residents w	ry track	07/24/2011		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155630	B. WIN			06/24/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ST 11TH STREET		
	CK RIVER LODGE				/ILLE, IN46173		
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TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1 ^	ract infections for a			history of urinary track infecti Resident #43 Care Plan was		
		history of urinary tract			immediately updated to inclu		
	infections for 1 of	of 5 sampled for urinary			plan of care interventions to	40	
	tract infections in	n a total sample of 14			prevent urinary track		
	(Resident #43).				infections.An MDS audit for a		
	Finding include:		residents with a history of UTI will be completed. At risk residents care plans will be updated, as may be necessary, to prevent				
	Review of the re	cord of Resident #43 on			urinary tract infections. The		
	6-20-11 at 12:45	p.m., indicated the			will review care plans and ca		
		ses included, but were			plan updates to ensure those		
	1	story of urinary tract			risk for urinary tract infection have a care plan in place. Th		
	infection.	20009 00 0000000					
	The nursing prog #43 dated, 5-23- the physician wa resident had a ch residents had a to chills and seeing there. The physic	gress notes for Resident 11 at 1:24 p.m., indicated as contacted due to the tange in condition. The temperature of 101.3, a people who were not can gave an order to send the emergency room for an areatment.			will be done weekly for eight weeks then monthly for four months. Any negative findings will be reorted to QAThe administrator shall monitor for compliance by reviewing nursing notes, 24 hour report sheets and CNA assignment sheets.Monitored by Administrator and DON		
	for Resident #43 the resident was Intravenously (I' Review on 6-20- Resident #43's p 3-14-11 to 6-3-1	al emergency room record dated, 5-23-11, indicated a urinary tract infection. s given Cipro (antibiotic) W). 11 at 12:45 p.m., of lan of care dated from 1, indicated there was no revent urinary tract					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155630		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING B. WING (X3) DATE SURVI COMPLETED 06/24/2011			
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE ST 11TH STREET /ILLE, IN46173	
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F0282 SS=D	p.m., indicated the developed for Refurther urinary traindicated she wanot, but she would time. 3.1-35(a) The services proving facility must be proving accordance with plan of care. Based on observative record review, the aresident's plan of drop and wheeled sheepskin, in the (Resident #34) Findings Included Resident #34's refo/21/11 at 10:25 included but were	ecord was reviewed on	F0282	The facility does provide ser by qualified persons in accordance with each reside written plan of care.Residen #34 wheelchair leg and foot was immeditely padded with sheepskin. The CNA assign sheet was updated.All CNA assignment sheets will be at with all care plans for accurand checked after any update accuracy.Resident #34's ince the sheepskin intervention of care plan. The sheep skin we placed on chair on 6-22-11.7 MDS coordinator will ensure CNA care plan items are on assignment sheet (care Plan	ents t's drop ment udited acy te for ludes n the vas The all the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ((X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	, DDIG	00	COMPI	ETED
		155630	A. BUI B. WIN	LDING		06/24/2	011
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	₹		1	ST 11TH STREET		
EI ATDO	CK RIVER LODGE				/ILLE, IN46173		
	OK KIVEK LODGE			ROSHV	TEEE, 114-017-3		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	-	TAG	,		DATE
					staff that perform services w qualified in all criteria. Othe		
	Resident #34's s	ignificant change			residents with identified nee		
	Minimum Data	set assessment dated			chair padding were reviewed		
	3/31/11, indicate	ed the following:			CNA assignment sheets we		
	Resident #34 ma	ade herself understood and			reviewed to ensure they con		
	usually understo	od others,her cognitive			planned interventions. The		
	1 -	ecision making were			administrator shall monitor for		
	1	aired, she required total			compliance by reviewing nu notes, 24 hour report sheets		
	1	persons for transfers, she			CNA assignment sheets. Th		
	1 *	e used a wheelchair, she			DON will review all cna	-	
	1	al limitation in range of			assignment sheets with care	e plan	
		•			updates weekly for the next		
	1	per or lower extremities,			weeks and monthly for the n	ext	
	and she was on l	Hospice care.			four months to ensure interventions for those at ris	l,	
					for skin tears are on the CN		
	A care plan for I	Resident #34 dated			assignment sheet. Any nega		
	3/14/11, indicate	ed the following: Problem			finding will be reported		
	- Potential for tis	ssue integrity impairment.			to QA.Monitored by Adminis	trator	
		reased mobility, bowel			and DON		
		ngile skin, and history of					
		oach - Keep foot drop					
		legs padded with					
		legs padded with					
	sheepskin.						
		D 11 + 110 A 1 1 1 1					
		Resident #34 indicated					
		1/2/11 - Skin tear to right					
		Pink in color with blood					
	noted on the old	dressing. Adaptic to					
	right shin, chang	ge every 3 days. 2/10/11 -					
	Skin tear to left	shin re-opened, 2					
) by 1 cm. Small amount					
	of blood on old dressing. Adaptic to right						
		rs. Change every 3 days					
		5/11/11 - Skin tear to left					
	snin measuring a	2.3 cm by 1.6 cm.					

	OF OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155630	A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMP 06/24/2	LETED	
	PROVIDER OR SUPPLIER		B. WING 00/24/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 904 EAST 11TH STREET RUSHVILLE, IN46173					
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	days. 6/14/11 - S	hptic and change every 3 kin tear to residents right ring 0.5 cm by 1 cm. nd wrapped.						
	indicated the foll Adaptic dressing tear. Cover with 5/6/11 - Adaptic Change every 3 c - Adaptic to right measuring 0.5 ce	s for resident #34 owing: 1/31/11 - to right lower leg skin gauze until healed. to left leg skin tear. days until healed. 6/15/11 t lower calf skin tear, ntimeters(cm) by 1 cm. x, change every 3 days,						
	wheelchair on 6/2 Resident #34's bi continuous move on the wheelchai and leg rests, wit board. Resident around her left lo Resident #34 ind her leg and foot.	ment while they rested r's elevated bilateral foot h an attached foot drop #34 had gauze wrapped ower leg dated 6/20/11. icated she had skinned No sheepskin was ent #34's wheelchair legs						
	on 6/21/11 at 10: transfer, Resider	s observed being her wheelchair to her bed 08 A.M. Prior to nt #34's bilateral legs the wheelchair's bilateral						

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
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NAME OF L	DD OLUBED OD GUDDU IEI		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	· ·		904 EA	ST 11TH STREET		
	CK RIVER LODGE				/ILLE, IN46173		
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TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s, with an attached foot					
	_	sheep skin was present on					
		wheelchair legs or foot					
	drop board.						
		s observed seated in the					
	1	ner wheelchair on 6/22/11					
	at 11:42 A.M. R	Resident #34's bilateral					
	legs were elevate	ed on the wheelchair's					
	bilateral leg and	foot rests, with an					
	attached foot dro	op board. No sheepskin					
	was present on F	Resident #34's wheelchair					
	legs or foot drop						
	Resident #34 wa	s observed being					
		her wheelchair to her bed					
	on 6/22/11 at						
		to transfer, Resident					
		gs were elevated on the					
		ateral leg and foot rests,					
		foot drop board. No					
		resent on Resident #34's					
		or foot drop board.					
	wheelchall legs	or root drop board.					
	An interview wi	th the Director of Nursing					
		1 at 4:03 P.M., indicated					
	' '	d a physician's order for					
	1	on because her skin was					
		ily. The DoN indicated					
	1 -	ould have had sheepskin					
		netal of her wheelchair leg					
		The DoN indicated she					
		ny sheepskin in Resident					
	#34's bedroom.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155630		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE S COMPL 06/24/2	ETED	
	PROVIDER OR SUPPLIER		904 EA	ADDRESS, CITY, STATE, ZIP CODE ST 11TH STREET (ILLE, IN46173		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Records staff #7 did not indicate t wheelchair legs p Medical Records sheepskin was ac CNA assignment when supportive	on 6/23/11 at 9:28 A.M., o keep her foot drop and badded with sheepskin. staff #7 indicated the lded on Resident #34's a sheet on 3/23/11, and devices were updated on the devices from 3/23/11				
F0314 SS=D	a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that a resident having precessary treatment healing, prevent in sores from develoting Based on observations.	prehensive assessment of ility must ensure that a rest the facility without es not develop pressure individual's clinical condition they were unavoidable; and pressure sores receives ent and services to promote infection and prevent new ping. action, interview and the facility failed to put place to prevent pressure	F0314	The facility does put interve in place to prevent pressure ulcers, to initiate treatment ordered by the physician an	:	07/24/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
THIE TELL	or conduction	155630	A. BUI	LDING		06/24/2	
		133030	B. WIN			00/24/2	011
NAME OF	PROVIDER OR SUPPLIE	3		1	DDRESS, CITY, STATE, ZIP CODE		
FLATRO	CK RIVER LODGE			1	ILLE, IN46173		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	ulcers, to initiate	e treatment ordered by the			identify open areas. Resider		
	physician and to	identify 5 open areas for			#23's Dr. and family notified 6-16-11. An MD order for	on	
	3 of 6 residents 1	reviewed for pressures			treatment was received on		
	ulcers in a samp	le of 14. (Resident #44,			6-16-11. All CNA and nursin	q	
	#43 and #23)				staff were retrained to edenti	-	
					and document newly identifie	ed	
					skin conditions per policy.		
	Findings in also de				Inservices will be given to		
	Findings include	÷.			all license staff on Physican		
					Notification, and Skin Treatm Management Protocol. Resi		
	/	at 11:35 a.m. staff CNA			#44 was reassessed. The ca		
	#2 and staff CN	A#3 were observed			plan shall be updated to refle		
	providing a trans	sfer from the wheelchair			current skin conditions, risk		
	to the bed with t	he hoyer lift and during			factors for impaired skin inte	grity,	
	interview at that	time, CNA			and interventions for		
		sident #44 did not have a			management. Resident #43		
		heelchair. Incontinence			was observed on an air matt on 6-20-11 at 12:30 pm. The		
		t #44 was provided and			alternating pressure air matti		
		en areas were observed:			itself is a pressure reducing		
	_ ^				device. Resident #43's care	plan	
	_	iddle abdomen below the			shall be updated to reflect al	I	
		l), approximately 4 cm			current skin conditions, risk		
	1 '	ng .3 cm wide, linear			factors for impaired skin inte	grity,	
	shaped, red in th	e center, surrounding skin			and interventions for	4D	
	no change in col	or and no drainage			management. Appropriate Norders shall be obtained as	טוי	
	- open area on th	ne coccyx, approximately			necessary. Treatment order	s for	
	2 cm x .3 cm, lir	near shaped, red in the			Resident #43 open areas we		
		ing skin no change in			clarified on 6-20-11. The res	sident	
	color and no dra	_			and the Resident's family		
		ne right inner thigh			received notification of the	dont	
	_	cm x 1.0 cm wide, linear			change in MD orders. Residual care plans shall be updated		
	1 11	e center, surroundings			reflect all current skin conditi		
	_	_			risk factors for impaired skin		
		n color and no drainage			integrity, and interventions for		
	_	ne right inner thigh next to			management. Appropriate M	D	
		ly 6 cm open area, 2 cm			orders shall be obtained as		
	long x .3 cm wid	le, linear shaped, red in			necessary. The DON shall		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155630			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL 06/24/2	ETED	
		100000	B. WIN			00/24/2	011
NAME OF I	PROVIDER OR SUPPLIER	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
FLATRO	CK RIVER LODGE			1	ST 11TH STREET ILLE, IN46173		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ing skin no change in			conduct weekly skin rounds for eight weeks to ensure		
	color and no dra	· ·			treatments, MD orders and o	are	
	_	e left upper buttock,			plans are appropriate and		
		5 cm x .4 cm oval shaped,			consistent with facility skin		
		rrounding skin no change			management protocols.CNA		
	in color and no c	Irainage			shall immediately report any irregularities to the nurse and		
					document the observations of		
	The record of re	sident #44 was reviewed			CNA assignment sheets. The	;	
	on 6/22/11 at 10	:35 a.m. Resident #44's			DON will review all new care	•	
	diagnoses includ	led but were not limited to			and care plan updates week the next eight weeks and mo		
	dementia, obesit	y, Alzheimer's disease,			for the next four months to e		
	hyponatremia (lo	ow sodium), diabetic and			those at risk for skin breakdo		
	anemia.				have a care plan in place. A		
					negartive finding will be repo		
	Resident #44's N	Minimum Data Set			to QAThe administrator shall monitor for compliance by	I	
	(MDS), assessm	ent, dated 6/10/11			reviewing nursing notes, 24	nour	
	indicated the fol	lowing:			report sheets and CNA		
	- makes self und	•			assignment sheets. Monitor	ed by	
	understood	3			Administrator and DON		
	- ability to under	stand others, usually					
	understands	, ,					
		xtensive assistance, with					
	2 plus physical a						
	1 ^ ^ -	lependence, with 2 plus					
	physical assist						
	1 * *	or corridor, activity did not					
	occur						
	- urinary contine	ence frequently					
	incontinent	,					
		ace, frequently incontinent					
	- risk of pressure						
	- unhealed press						
	ulcers at each sta	of unhealed pressure					
	i uiceis at each sta	120	- 1				I

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155630	B. WIN			06/24/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	C		904 EA	ST 11TH STREET		
	CK RIVER LODGE				/ILLE, IN46173		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	- stage 1, 1						
	_	e 2 pressure ulcers, 3					
	1	tage 2 pressure ulcer,					
	6/6/11						
	Resident #44's p	hysician's orders on the					
	1	, dated, 6/11, indicated "					
	1	(yeast infection), apply					
	1 1 1	ominal, fold twice daily,					
	1 ^ -	nfection) 1% cream every					
		led until healed to inner					
	1	and buttock, vitamin A &					
	• • •	ly topically to knees,					
	1	left shin open area, clean					
	1	ner and apply duodenum					
	every 3 days unt	* * *					
	every 3 days unt	ii iicaica.					
	Resident #44's c	are plan dated, 6/14/11,					
	indicated the fol	lowing: "Problem, at risk					
	for further skin p	pressure areas. Tissue					
	tolerance time =	every hour to 1 and 1/4					
		ntely. Has skin pressure					
		, left inner shin and left					
		roach, turning and					
	1	ery hour to 1 and 1/4 hour					
		laily every shift while in					
		nair. Cue to self help as					
		assist of 1 or 2 depending					
		given time. Monitor and					
	1	s to nurse as needed. Use					
	1 -	ws to keep resident					
	comfortable in different positions. Has a						
	pressure relieving mattress on her bed.						
	1 -	needed to assist with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155630		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 06/24/2	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 904 EAST 11TH STREET RUSHVILLE, IN46173					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	turning while in further skin press resident will be reach shift daily wheelchair and with skin pressur inner shin and le assessment. Resident #44's "s management repleft knee, date of admission, 6/6/1 cm x 1.9 cm, yel The "skin condit dated, 6/21/11, la except for the lefulcer. Interview with the (DON) on 6/22/1 the 5 open areas open until today open areas yester looked at the CN	bed. Goal, To prevent sure issues as evidence by repositioned throughout while in bed and will show improvement re areas on left knee, left fit outer shin by next skin condition ort" indicate area affects, rorigin present on 1, stage 2, size cm, 0.5 low/red. ion management report" necked documentation of knee, stage 2, skin the Director of Nursing 1 at 3:10 p.m., indicated observed today were not and she did not have the reday because the DON IA assignment sheets and		I	CROSS-REFERENCED TO THE APPROPRI	ATE		
	documented. Sh been treating her	rt and nothing was e also indicated we have red excoriated areas s, peri area and buttocks der.						
	Resident #44's no following:	ursing notes indicated the						

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Event ID:

55UK11

Facility ID:

001126

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155630		ľ	ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		100030	B. WIN			06/24/2	UII
	PROVIDER OR SUPPLIER			904 EAS	DDRESS, CITY, STATE, ZIP CODE ST 11TH STREET		
FLATRO	CK RIVER LODGE			RUSHV	ILLE, IN46173		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		a.m., general skin					
	· ·	olor adequate cool to					
	1	s treatment to areas of					
	_	ers. Skin color adequate					
	areas of skin per	l dry has treatment to					
	_	p.m., weekly skin					
		lent has excogitation in					
		es are noted on arms and					
	1 ^	een present and are					
	*	had blisters that are					
	_	open areas were noted					
	_	Treatment nurse					
	notified.						
	- 6/22/11 at 3:37	p.m., skin problem,					
		v areas noted today. 1.)					
	Abdomen 4.2 cm	x 0.3 cm, stage 2, red					
	with no drainage	or odor noted,					
	granulation tissue	e present. 2.) Right inner					
	upper thigh 6 cm	x 0.8 cm stage 2, red					
	with no drainage	or odor noted,					
	-	e present. 3) Right inner					
	lower thigh 1.5 c	m x 0.3 cm, stage 2, red					
	with no drainage	· ·					
	~	e present. 4.) Coccyx 1.5					
	l	ge 2, red with no drainage					
		anulation tissue present.					
	l '	0.6 cm x 0.4 cm, stage 2,					
		age or odor noted,					
	granulation tissue	*					
	'	vation on 6-20-11 at					
		dent #43 was eating					
		Resident #43 bed was on					
	an air mattress ar	nd the resident did not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

55UK11

Facility ID:

001126

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SUI		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLET:	
		155630	B. WIN			06/24/201	1
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
FLATRO	CK RIVER LODGE			I	ST 11TH STREET 'ILLE, IN46173		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	_	relieving boots on either					
	_	e relieving boot was					
	' "	ident's love seat. During time Resident #43					
		e does wear the boot					
	sometimes.	c does wear the boot					
	Sometimes.						
	Review of the re	cord of Resident #43 on					
		p.m. indicated the					
		nitted to the facility on					
	3-14-11.						
	The resident's red	cord reviewed on 6-20-11					
	at 12:45 p.m., inc	dicated Resident #43's					
	_	ed, but were not limited					
	to, Cerebral Vasc	cular Accident (CVA)					
	(stroke), breast of	cancer with met's (spread)					
	to the lymph nod	les and spine/bone,					
	diabetes mellitus	and left hemiplegia.					
	_	al notes for Resident #43					
	· ·	dicated the resident had					
	_	ound on the achilles					
	l *	ft heel, which was					
	healing. Patient i						
		nursing monitors wound,					
	"	d signs and symptoms of					
	infection and fur	ther skin breakdown.					
	The continuit	f ooms massed fus 41					
	1	f care record from the					
	_	Resident #43 dated,					
		ed left heel allevyn					
	dressing.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155630		(X2) MULTIP A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE S COMPL 06/24/2	ETED		
	VIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 904 EAST 11TH STREET RUSHVILLE, IN46173					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
T ## the read of t	The nursing prog 43 dated, 3-14-1 ne resident was a resident's "skin is ry." The resident wo people to train equires 1 or 2 standard and the resident's more than the resident occasionally slided hair. The resident objects of the care plan for roblem date of 3 resident was unall ed, related to left econdary to CVA-13-11 indicated the only when reft heel off of better the off of the care only when reft heel off of better the resident of the resident was unall ed, related to left econdary to CVA-13-11 indicated the only when reft heel off of better the resident of the original transfer to the resident was unall ed, related to left econdary to CVA-13-11 indicated the only when reft heel off of better the resident was unall the resident was unall the resident was unall the resident to the resident was unall the resident the resident to the resident was unall the resident the resident the resident the resident the resident the resident was unall the resident	ress notes for Resident 11 at 8:37 p.m. indicated a new admission. The s pale in color, warm and at requires a hoyer lift and ensfer. The resident aff for bed mobility. ress note for Resident 11 at 9:37 p.m., indicated bility was very limited. asional made slight extremity position. The make frequent and es alone. The resident mal assist and has some sitioning. The resident es down in the bed and ant is bedfast and confined ders for Resident #43 adicated no treatment						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155630	B. WIN			06/24/2011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	ST 11TH STREET	
FLATRO	CK RIVER LODGE			RUSHV	/ILLE, IN46173	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
IAG		LSC IDENTIFYING INFORMATION)		TAG	BLI ICILIACI)	DATE
	1 .	sitioning program every				
	hour daily, every	shift.				
	The physician tel	anhana andar far				
	The physician tel	•				
		ed, 5-6-11, indicated				
		l a stage one pressure				
	area to the left he	_				
	` ′	by 2 cm. "May we have				
		ΓID (three times a day)				
		lso elevated (L) heel l area healed." The				
	physician respon	se was "yes".				
	The Minimum D	ata Set (MDS)				
		esident #43 dated,				
		d the following: bed				
	· ·	ve assistance of two				
	1 -	total dependence of two				
	1 ^ ^ '	oom- did not occur,				
	1	- extensive assistance of				
	1	aled pressure ulcer-yes,				
	number of stage	_				
		1				
	The pressure sore	e, stasis ulcer and other				
	1 ^	5-9-11, for Resident #43				
	· ·	owing: the resident				
		1 pressure ulcer at the				
		measuring 1.4 cm by 2				
	1 *	in color, the skin was				
		atment was A&D three				
		elevate heel until healed.				
	The pressure sore	e, stasis ulcer and other				
	_	5-16-11, for Resident				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		155630	B. WIN			06/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			904 EAS	DDRESS, CITY, STATE, ZIP CODE ST 11TH STREET		
FLATRO	CK RIVER LODGE			RUSHV	ILLE, IN46173		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		e following: the resident's		1710	·		DATE
		e ulcer measured 1 cm by					
	1 cm.	, 4.1.01 1.1.040 4.1.0 1 0.1.1 0 j					
	The pressure sore	e, stasis ulcer and other					
	· ·	5-23-11, for Resident					
		e following: the resident's					
	left heel pressure	ulcer was healed.					
	T1.						
	1 ^	e, stasis ulcer and other 6-6-11, for Resident #43					
	· ·	ident acquired a stage II					
		the facility on her left					
	1 ^	ng 1 cm by 0.6 cm. The					
		and red. The treatment					
		ne every shift and as					
	1	as documentation of the					
		the resident's coccyx.					
	•	,					
	The physician or	der for Resident #43					
	dated, 6-7-11, inc	dicated the resident was					
	to have Calmose	ptine every shift and as					
	I -	x. There was no physician					
		ent of the pressure ulcer					
	on the left buttoc	eks.					
	The nursing pro-	rraga natas for Dasidant					
	• • • •	gress notes for Resident 1, indicated the resident					
	l '	essure sore on the left					
		ng 1 cm by 0.6 cm. There					
		tation of the pressure					
	ulcer on the resid	-					
		···					
	The pressure sore	e, stasis ulcer and other					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155630	B. WING		06/24/2011
				ADDRESS, CITY, STATE, ZIP CODE	!
NAME OF I	PROVIDER OR SUPPLIER	-	904 EA	AST 11TH STREET	
	CK RIVER LODGE			VILLE, IN46173	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
IAG		LSC IDENTIFYING INFORMATION)	TAG	BEFFEERET	DATE
	· ·	6-13-11, indicated the			
	1 *	a stage II pressure ulcer			
	1	the facility on 6-6-11,			
	I -	n by 1 cm. The treatment			
	was Calmoseptin	e every shift and as			
	needed. The resid	dent's pressure ulcer on			
	the left buttock n	neasured 2.4 cm by 0.5			
	cm.				
	During observati	on on 6-20-11 at 2:05			
		d CNA # 2 cleaned			
	l * '	eri area. When queried if			
	1	suppose to have a			
		g boot on her left foot.			
	l -	A #2 indicated they were			
		indicated Resident #43			
	l -	ess for her bed on Friday			
	l ` ′	iew with the wound nurse			
		ated she would find out,			
	1	working with resident to			
	l ~	The wound nurse then			
	washed her hand	* *			
	1 ^	eam with a Q- tip to the			
		tock and coccyx. The left			
	buttock was red	with some yellow and			
	coccyx was red a	and pink. The wound			
	nurse indicated C	Calmoseptine was the			
		ility was using every shift			
	to the coccyx and				
	[
	Interview with R	N #1 on 6-20-11 at 2:40			
	p.m. indicated sh	e was unable to find an			
	treatment order f	or Resident #43's			
	pressure ulcer on	the left buttock except			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPLI		
ANDILAN	or connection	155630	A. BUII			06/24/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ST 11TH STREET		
FLATRO	CK RIVER LODGE			1	ILLE, IN46173		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		6-20-11. RN #1 provided					
	· •	dated, 6-20-11 at 1:50					
	1 ^	t #43 that indicated the					
		ered Calmoseptine to					
	1 * *	every shift and as					
		red Calmoseptine to left					
	l -	ft and as needed until					
	healed.						
	Interview with th	ne wound nurse on					
		.m., indicated the facility					
	·	both of Resident #43's					
	·	vith Calmoseptine. The					
	_	icated she thought the					
		ote an order for both					
		not. The wound nurse					
	· ·	not usually do Resident					
		hat LPN #5 did. The					
	·	icated she was not sure					
	what happened a	nd felt that it was an					
	miscommunication						
	Intom-i :41. 41	Dimentan Of Name					
		ne Director Of Nursing 11 at 3:00 p.m. indicated					
	· ′	umentation of the					
	^ -	ily notification of					
	The DON indicate	ressure ulcers on 6-6-11.					
		f the physician or family					
		esident's pressure sore on					
		•					
		etting larger on 6-13-11.					
		ted the wound nurse was					
		tify the physician about					
	pressure ulcers.	The DON indicated if the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155630		(X2) MU A. BUII B. WIN	DING	nstruction 00	(X3) DATE S COMPL 06/24/2	ETED	
	PROVIDER OR SUPPLIER	!	P . W. I.	STREET A	DDRESS, CITY, STATE, ZIP CODE ST 11TH STREET ILLE, IN46173		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	another nurse we whoever receive pressure ulcers we The DON indicated a pressure ulconduction and a pressure ulconduction and a pressure ulconduction and reports. The resident and a pressure ulconduction and a pressure ulcondu	ne Dietary Manager on o.m. indicated the facility Resident #43 2 eggs for the to the resident's cer. The Dietary Manager					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE S COMPLE	ETED	
		B. WIN			06/24/20)11	
	PROVIDER OR SUPPLIER		-	904 EA	ADDRESS, CITY, STATE, ZIP CODE ST 11TH STREET (ILLE, IN46173		
		TATE VENT OF DEFICIENCIES	-		ILLE, IIV+0170		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	pressure ulcer x 2	2 to coccyx and left					
	buttock." Will re	quest to add an					
	multivitamin wit	h minerals daily in					
		free shake twice a day to					
	provide additiona	al protein and calories.					
		1 CD 11 . #22					
	l '	e record of Resident #23					
		05 p.m., indicated the ses included, but were					
		bility, dementia and					
	anemia.	omity, dementia and					
	aneima.						
	The MDS assessi	ment for Resident #23					
		dicated the following:					
		al dependence of one					
	person, transfer-	total dependence of one					
	person, walk in r	oom- did not occur,					
		- total dependence of one					
		ontinence- frequently					
		powel continence-					
	frequently incont	inent.					
	T1						
		e, wound, stasis ulcer					
	skin sheet for Re	· · · · · · · · · · · · · · · · · · ·					
	· ·	d the resident acquired are ulcer on the left					
		cility measuring 1.3 cm					
	by 0.6 cm, the ar	-					
		treatment was Baza clear					
	-	and as needed. There					
	·	tation the physician was					
		atment ordered by the					
	physician.	,					

NAME OF PROVIDER OR SUPPLIER 904 EAST 11T FLATROCK RIVER LODGE RUSHVILLE, I	SS, CITY, STATE, ZIP CODE TH STREET	24/2011
(VA) ID SUMMARY STATEMENT OF DEPUGENCIES		
	OSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
The physician order dated 6-16-11 indicated Resident #23 was ordered sween cream to left buttock pressure area every shift.		
Interview with the DON on 6-23-11 at 1:05 p.m. when queried about Resident #23 receiving Baza cream to the left buttock and no documentation of the resident's physician or family being notified of the pressure ulcer on 6-13-11, the DON indicated the facility got an physician order for the resident's pressure ulcer on 6-16-11. This indicated the facility provided treatment to Resident #23's pressure ulcer without an physician order for 3 days. The facility "Skin Treatment Management Protocol" provided by the Administrator on 6-22-11 at 2:30 p.m., included, but were not limited to, the following: An stage II pressure ulcer is partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. The treatment protocol is notify the physician/obtain orders/diagnosis. Notify the Power Of Attorney (POA)/Legal representative. Notify the wound nurse and person at risk committee and 24 hour report entry. Re-evaluate/implement prevention interventions.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/19/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUI	LDING	00	COMPL	ETED
	REFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 904 EAST 11TH STREET RUSHVILLE, IN46173 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		06/24/2	(X5) COMPLETION DATE
F0323 SS=D	The facility must e environment rema hazards as is poss receives adequate devices to prevent Based on observarecord review, the resident's legs protears, for a resident tears, in that the wheelchair legs with sheepskin, and far operating instruction resident with an interesident with an interesident sobserve in the total sample. Findings Include 1.) Resident #34 on 6/21/11 at 10:	ation, interview, and e facility failed to have a betected to prevent skin out with a history of skin resident's foot drop and were not covered with ailed to follow the owners tions for transferring 1 invacare lift, for 3 and for Invacare transfers, e of 14. (Resident #34).	FC	0323	The facility does ensure that resident environment remain free of accident hazards as it possible and each resident receives adequate supervision and assistance devices to praccidents. Resident #34 wheelchair legs and foot dropedal was immediately padd with sheepskin on 6-22-11. CNA assignment sheet was updated. Resident #34 care did include the sheepskin intervention. All CNA assignmenet sheets will be audited with the care plans for accuracy and checked for accuracy after any update. nursing staff involved in the transfer of resident #34 was immediately reeducated on the	as as son revent ped The plan or	07/24/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

55UK11

Facility ID:

001126

If continuation sheet

Page 29 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155630		A. BUIL	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/24/2	ETED	
NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE			B. WING OU/24/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 904 EAST 11TH STREET RUSHVILLE, IN46173				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY)				(X5) COMPLETION DATE
	anemia, osteopor fragile skin. Resident #34's si Minimum Data si 3/31/11, indicate Resident #34 mai usually understood skills for daily do moderately imparted dependence of 2 did not walk, she had no functional motion in her uppand she was on High A care plan for Right 3/14/11, indicate - Potential for tis Related to - decreincontinence, franskin tears. Approand wheel chair is sheepskin. Nurses notes for the following: 2 shin re-opened. In noted on the old right shin, chang Skin tear to left si centimeters (cm)	et assessment dated d the following: de herself understood and od others,her cognitive ecision making were ired, she required total persons for transfers, she used a wheelchair, she I limitation in range of per or lower extremities, Iospice care. Lesident #34 dated d the following: Problem sue integrity impairment. eased mobility, bowel gile skin, and history of each - Keep foot drop egs padded with Resident #34 indicated /2/11 - Skin tear to right Pink in color with blood dressing. Adaptic to e every 3 days. 2/10/11 -			operating instructions for transferring residents with the Invacare lift and counseled frailure to follow protocols. A nursing staff will be inserviced the operating instruction for transferring residents with the The DON will monitor CNA compliance for transferring residents with the Invacare liand audit all CNA assignments sheets, for accuracy, with carplan updates. This will be doweekly for eight weeks, then monthly for four months. Any negative findings will be report to QA Monitored by Administrand DON	or III ed on e lift. ft ont re one	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BIIII	DING	00	COMPL	ETED	
I 155630		A. BUILDING B. WING 06/24/2011					
		l .	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	8			ST 11TH STREET		
FLATRO	CK RIVER LODGE				'ILLE, IN46173		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	PRIATE DATE	
	and left shin tear	rs. Change every 3 days					
	and as needed.	5/11/11 - Skin tear to left					
	shin measuring 2	2.3 cm by 1.6 cm.					
	1	aptic and change every 3					
	1	Skin tear to residents right					
	1 *	aring 0.5 cm by 1 cm.					
	Adaptic placed a						
	Transfer placed a	ma wruppod.					
	Physician's orde	rs for resident #34					
	1 -	lowing: 1/31/11 - Adaptic					
	1						
	dressing to right lower leg skin tear.						
	Cover with gauze until healed. 5/6/11 - Adaptic to left leg skin tear. Change						
	1 ^	•					
	1 ' '	il healed 6/15/11 -					
	1 ^ ~	lower calf skin tear,					
		entimeters(cm) by 1 cm.					
	Cover with Kerl	ix, change every 3 days,					
	and as needed.						
	Dagidant #24	s observed seated in her					
		/20/11 at 2:12 P.M.					
	Resident #34's b	_					
		ement while they rested					
		ir's elevated bilateral foot					
	and leg rests, wi	th an attached foot drop					
	board. Resident	#34 had gauze wrapped					
	around her left le	ower leg dated 6/20/11.					
	Resident #34 indicated she had skinned her leg and foot. No sheepskin was						
	~	lent #34's wheelchair legs					
	or foot drop boa	· ·					
	Resident #34 wa	s observed being					
	1	her wheelchair to her bed					
	L mansioned moni	ner wheelenan to her bed					

l 155630		(X2) M A. BUI		INSTRUCTION 00	(X3) DATE S		
		B. WIN			06/24/2	011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	1	
				1	ST 11TH STREET		
FLATRO	CK RIVER LODGE			RUSHV	'ILLE, IN46173		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		08 A.M. Prior to	+	IAG	DEFICIENCE (DATE
		nt #34's bilateral legs					
	· ·	the wheelchair's bilateral					
		s, with an attached foot					
	-	sheepskin was present on					
		heelchair legs or foot					
	drop board.						
	Resident #34 was	s observed seated in the					
	dining room in h	er wheelchair on 6/22/11					
	at 11:42 A.M. Resident #34's bilateral						
	legs were elevated on the wheelchair's bilateral leg and foot rests, with an						
	attached foot dro	p board. No sheepskin					
	was present on R	esident #34's wheelchair					
	legs or foot drop	board.					
	Resident #34 was	C					
	transferred from	her wheelchair to her bed					
	on 6/22/11 at						
		to transfer, Resident					
	l -	gs were elevated on the					
		teral leg and foot rests,					
		foot drop board. No					
		resent on Resident #34's					
	wheelchair legs of	or foot drop board.					
	.	1.4 D' (O) '					
		h the Director of Nursing					
	1 '	1 at 4:03 P.M., indicated					
		l a physician's order for					
	-	n because her skin was					
	*	ly. The DoN indicated					
		ould have had sheepskin					
	on the outside metal of her wheelchair leg						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155630		A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 06/24/2	ETED	
	100000		B. WIN			00/24/2	011
NAME OF	PROVIDER OR SUPPLIE	3		1	ADDRESS, CITY, STATE, ZIP CODE		
FI ATRO	CK RIVER LODGE			1	ST 11TH STREET ILLE, IN46173		
				L	ILLL, INTO 175		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	ŧ	The DoN indicated she					
		ny sheepskin in Resident					
	#34's bedroom.	-y					
	A CNA care assi	gnment sheet for					
		ovided by Medical					
	1	on 6/23/11 at 9:28 A.M.,					
		to keep her foot drop and					
		padded with sheepskin.					
	Medical Records	s staff #7 indicated the					
	sheepskin was added on Resident #34's CNA assignment sheet on 3/23/11, and when supportive devices were updated on 5/3/11, supportive devices from 3/23/11						
	dropped off, and	should not have.					
	2.) Resident #34	4 was observed being					
	transferred from	her wheelchair to her bed					
	on 6/21/11 at 10	:08 A.M., by CNA #4 and					
	CNA #5, with th	e use of a Invacare lift.					
	CNA #4 operate	d the lift while CNA #5					
		4 opened the Invacare lift					
	~	dent #34's wheelchair.					
		ng was attached to the lift					
		4 was lifted. CNA #5					
		lchair backwards and					
		he Invacare lift legs,					
		ft, guided the lift to					
		ed, and placed the lift					
	~	ed. Resident #34 was					
		ed. An interview with					
		ed she closed the Invacare					
	_	she had more control					
	over the lift with the legs closed. CNA #4						

STATEMENT OF DEFICIENCIES (X1) I		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
155630		B. WING 06/24/2011					
		<u> </u>	P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ST 11TH STREET		
FLATRO	CK RIVER LODGE			1	/ILLE, IN46173		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		sed the Invacare lift legs					
		ere wires under the bed.					
		ed Resident #34's bed					
		sometimes the wires still					
	hung down.						
	An interview wi	th CNA #4 on 6/23/11 at					
		ated she was trained not					
		care lift legs when					
		e					
	transferring a resident because leaving the legs open helped balance the lift. CNA #4 indicated she automatically closed the lift						
	legs when she placed them under a bed,						
		ull the lift legs straight					
	_	ted "I just have a bad					
		2					
	habit of doing th	at".					
	Resident #34 wa	s observed being					
		her wheelchair to her bed					
	on 6/22/11 at						
		NA #4 and CNA #6, with					
	1	care lift. CNA #6					
		while CNA #4 assisted.					
	_	the Invacare lift legs					
		#34's wheelchair. The					
		as attached to the lift and					
		s lifted. CNA #4 moved					
		ackwards and raised					
	Resident #34's bed. CNA #6 turned the						
		he lift to Resident #34's					
	1	the lift legs under the bed					
		sition. Resident #34 was					
		ed. CNA #6 had no					
	difficulty placing	g the Invacare lift legs					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD B. WING		nstruction 00	(X3) DATE : COMPL 06/24/2	ETED	
NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE				904 EAS	DDRESS, CITY, STATE, ZIP CODE ST 11TH STREET ILLE, IN46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ΓE	(X5) COMPLETION DATE
		34's bed in the opened vacare lift legs were not ires.					
	instructions indic Operating the particle of t	ner and operating cated the following: tient lift WARNING -" s lift with the legs in EN POSITION and ce. The base legs must be en position at all times for ent safety when lifting a patient".					